Radical Collaboration: Breaking Down Barriers, Driving Towards Equity

Rebecca Boss:

Good afternoon and welcome. It is afternoon. And that was a tough keynote speaker to follow. And today you've heard from a number of panelists about the importance of mental health in America. We've heard about 988 implementation. We've heard about the importance of workforce development. We've heard about the importance of innovation in this space. They're critical topics to address in mental health reform but I will tell you as someone who oversaw the Department of Behavioral Healthcare in a state that had one of the highest rates of overdose in 2016, that collaboration is key.

The panel that we have here assembled today, this esteemed panel, is going to discuss the importance of collaboration across numerous sectors that can support mental health across the life cycle and improve health equity. So please join me in welcoming, Dr. Jennifer Bronson, who is the senior director of consulting and research at NRI. Marc Dones, who is the chief executive officer of the King County Regional Homelessness Authority. Melissa Rowan, who is the chief operating officer of the Meadows Mental Health Policy Institute. And Reggie Williams, who is the vice president of the International Health Policy and Practice Innovations at the Commonwealth Fund.

So this panel will provide an overview of innovative ways in which stakeholders across multiple fields are partnering and coordinating to improve the mental health and substance use disorder ecosystem. And so I'd like to start by asking, what does the ideal collaborative mental health system look like, especially one that supports wellbeing across the life cycle? Dr. Bronson.

Dr. Jennifer Bronson:

Thank you for having me here. So the ideal mental health system, I'm going to assume and kind of place it in a society where our social problems have been drastically reduced, since that impacts our mental health. But the ideal mental health system, it would be based around prevention. Prevention, early identification and intervention. Our system right now is too reactionary and we wait often until the crisis occurs before being able to identify people who need help, communities that need help. So, moving the whole system upstream and trying to capture and catch people earlier, one that is culturally appropriate, trauma informed and recovery oriented. We want to avoid re-traumatizing people when they go to an inpatient, when they go to jail, those are not fun places, and we want to support them during the continuum of their recovery system. So for me, the answer is really prevention and that is going to set you on a path for wellbeing throughout your life course.

Marc Dones:

Hi everyone. Thank you all for having me. I would say two things. So one would be, an ideal system is built sort of ground up by the people who are going to be most impacted by it and the people who will be utilizing it. I've spent an inordinate amount of my career now, a weird thing to say, like sort of trying to bend government to be populated by and driven by the people who are trying to use it. So the Regional Homelessness Authority, which I have the privilege of stewarding, is comprised of 70% folks who identify as having experienced homelessness or some form of housing insecurity. And a lot of folks are also otherwise system impacted. I, myself, have experienced housing incivility. I also, I guess this is relevant here, was hospitalized twice in my teens for two psychotic episodes. I have like a range of things going on, they're well managed now. We love pharmacology.

But one of the things that I would say right, is that absent that kind of direct stewardship, we often spend, I think, criminal amounts of time missing the point and just like fundamentally not doing

the right thing and insisting that this time for some reason the result will be different than the 37 years we tried it before.

And then the second thing I would say is housing. Like boy howdy housing. Everything is worse when you are not housed, everything. And in fact. what we often see in the experiences of folks who come to experience homelessness is that the vast majority of their very serious like Axis 1 diagnoses, psychotic spectrum diagnoses, the onset is after the experience of homelessness. And I think that's really critical. Because oftentimes I think to your point about early intervention. We tell ourselves this narrative or allow this narrative to be told that people are experiencing homelessness because of a mental health condition, when in reality they are experiencing a mental health condition because our society has failed them. So housing.

Melissa Rowan:

It's nice to be here this afternoon. It's always tough to be the panel after lunch. Like are people on their way to their nap time? So I work at the Meadows Mental Health Policy Institute. We are in the State of Texas. And our goal is for Texas to lead the nation in mental healthcare. So watch out, I know we're not always thought of that way. I think that from my perspective that mental health is healthcare. So I think that fundamentally, if we could get to a place where we're talking about health systems and mental health is a specialty within that just like for any other disease state, we will have made huge progress because then we could talk about the things that are wrong in the healthcare system. But what we have now is a system that really grew up outside of the healthcare system, so we have a lot of challenges that require radical collaboration to change that are related to mental health and substance use disorders in the way that we regulate them, the way we pay for them, the way we deliver services. And we have all the issues that come with the US healthcare system.

So in some ways, progress would be just having the problems that come with the US healthcare system. And so I think when we have conferences and we begin to really talk about healthcare and we talk about mental health and substance use disorders in that frame, that's to me real progress, but that's going to take a lot of work across systems to get there.

Reggie Williams:

What they said.

But seriously, hello, my name's Reggie Williams from the Commonwealth Fund. And I couldn't start this conversation by thinking about the idealized state, without thinking about two things that are very important. One, that's ensuring health insurance, coverage access for everyone in the United States. I think that's a vital part of ensuring that people have access to services. Then two, ensuring that healthcare is affordable. And so thinking about ways that we can make care more affordable and accessible to people. And so with those as baselines, I think there are three things to consider for an idealized state in the future. One is integrating mental health services, behavioral health services, substance use services into the healthcare system. Stop treating it as if it's something different and it's not a part of our everyday lives. As the gentleman said earlier, head and heart are connected and so we should treat them equally. And so, that means integrating mental health services into things like primary care in a much more active way so that we can ensure that when people get that open door into meeting their particular needs, when there is that opportunity for early diagnosis, that they're getting access to services that they ultimately want that help them.

The second thing that we could really think about in our idealized healthcare system, mental health system, is having a broad variety of providers. There are a spectrum of people that can provide services and supports to individuals in the mental health space. And so whether it's a peer support

specialist or community health worker or the physician that you may need or are people that specialize in crisis, we need to have a wide variety of people providing services. And those services need to be respected and paid for in our various systems.

Then the final thing I would say is leveraging technology excellent there is an opportunity that we have to take some of the learnings that we've had, and really relaxing a lot of the rules around how telemedicine is used. Supporting the use of evidence based digital solutions. And doing simple things like allowing text messages and other phone calls and services supports be a way in which people can access services. And so those would be three features that I would think would be really important for our future.

Rebecca Boss:

One of the things that has struck me sitting here listening throughout the day is how people have been able to share personal experience with mental health and have been free to do so. And I think that by addressing stigma, we've allowed people to start to share more freely their own experiences. And in that way, it helps to bring potential collaborators to the table who wouldn't have been partners in the past, who now can be.

So, I'll follow suit and let you know that in addition to overseeing behavioral healthcare systems, my sister in 2009 committed suicide on Mother's Day weekend and was found by her adult son. And I share that with you for two reasons. One, is that when 20% of the United States adult population pre-COVID suffer from a mental illness at some point in their life or live with mental illness at some point in their life, this is an issue that impacts all of us. I think it would be challenging to say that there's any of you out there that haven't been directly impacted by mental health, either personally or with someone that you love. Two and a half weeks ago another member of my family attempted suicide and was put on life support. We really thought that he would not make it. He has actually pulled through, but this is an individual with multiple comorbidities, multiple issues with social drivers of health. And my fear is that he will return home with the same siloed system of care that he was receiving before and will continue to struggle as he has for the last 20 years with illnesses that are not well coordinated and cared for.

So, so I share that with you as well, and then turn to my panelists and ask you, where is additional collaboration needed to address mental health?

Dr. Jennifer Bronson:

So there's no shortage of groups and people that we can collaborate. One of the key ones though, is the criminal legal or criminal justice system. I'm also a person with lived experience co-occurring substance use and mental health disorders. I'm in recovery for alcohol and I've been to jail. And I remember vividly sitting in there thinking we are all here because we have mental wellness or substance use problem and/or were poor and that's never left me. And so I think the criminal justice system crossed the entire sector. So talking about 911 dispatchers, law enforcement, judges, lawyers, defense... I can't think of the right word right now. Public defenders, correctional officers, facilities, probation officers. We need that whole continuum to get on board and partner with mental health and for mental health to partner with them in a way that's appropriate as well, and not come in and try and bulldoze and tell them how it is and to make it a real trauma-informed recovery-oriented partnership.

The second area, and I would be remiss not to mention this I've been a violence trauma researcher for 17 years, is gun violence prevention. Over 55, 60% of gun violence deaths in America are suicides. A large number of those can be prevented. In addition, the trauma that is left from people who

have survivors of gun violence, murders, suicides, and so on and so forth. And we're doing a very poor job of not making some of those links in this country.

Rebecca Boss:

We don't have to go in order. So, Reggie.

Reggie Williams:

Yeah. The one thing I'd like to add to the discussion is the fact that healthcare in the US has an opportunity to make change that's multi-sectoral. And so when you look at the US spending on healthcare, we spend nearly 17% of our gross domestic product on healthcare, that is far higher than any other high income country. Yet our outcomes, no matter how you measure them are much lower. People are dying sooner, they're dying younger. And then you also look at something like social services spending. And for every dollar that we spend on social services, other countries are spending $2, $3. And so healthcare has this opportunity in the United States to engage with housing, to engage with employment, to engage with education, to engage with food and nutrition, to provide services and supports that people need to ultimately live the healthy lives that they want.

The drivers of health are so important to the way people experience care, experience life. And we, as people, that are working in healthcare, have an opportunity to affect that just because of the sheer resources that we have at our disposal. So taking those resources and putting them towards things that we know are going to get the good outcomes is an opportunity we all have. And so I hope we can think about doing that in the future.

Melissa Rowan:

And I would add that we know mental health issues are really childhood illnesses. I mean that most, 75% of all mental health issues show before someone reaches young adulthood. But the fact is we don't screen and we don't have early intervention and treatment. Most people 8 to 10 years after symptoms emerge get into some form of treatment. And so where does that happen? And we've heard some about the crisis system today. So you end up seeing people when the symptoms are so severe you have to pay attention because someone on the street could see that this is a problem. And so if we really become a part of the healthcare system, where does that start for most kids? That's your primary care doctor. Most people, no matter what their income level is has a primary care doctor that they see at least once a year. Because most kids are insured even in states with high un-insurance rates. And so early detection and screening starts there. And primary care doctors do a lot of that work now, but they need support and they need training.

I know someone spoke earlier about the collaborative care model, that's a model that we're working very hard to implement throughout the State of Texas. Because we believe that the first place that you can reach people is in primary care. And if we can get people early, then they don't all have to go to specialty care. There's many things that primary care physicians with the support of psychiatric consultation and a behavioral healthcare manager can manage in their practice. Like they do a lot of other disease states. PCPs take care of a lot of healthcare in this country, but we've always had mental health as something else. There are models that exist to do that are paid for. And so it's a matter of getting the primary care of physicians to understand that and to feel supported and taking on mental health screening, early detection and treatment in primary care. So that we can save that valuable space where we have such workforce shortages in specialty care for people that really need that who have more severe conditions that can't be managed outside of a specialty care setting.

So I think that reframing how we think about mental health particularly as a childhood disease changes the way we talk about treatment. And then hopefully people can get treatment before they get to a place where they feel like they have no other options or they end up in a justice system that's not a treatment system. Those are the things that we have a lot of work to do around all of these issues. But from my perspective, if we can get this done in primary care early with kids, you change the trajectory of people's lives.

Marc Dones:

Only thing I would add is I think from my perspective we have to shift what we think of as residential treatment, long term care. And in both instances, I think that what we have done is create very sort of one size models and deployed them in ways that I often see doing harm, particularly for... I'm a queer, non-binary person, I'm also black obviously in case that was not clear. Sometimes it's not, I don't know. And to that end I often see my communities the most mangled, to be honest, by that one size fits allness. And so I do think that there is a need to rethink, for example, in my community, our permanent supportive housing, which is supposed to be one of our strongest long-term care assets for folks who have any type of long-term disability, including mental health or behavioral health and we're just not equipped anymore. We're seeing folks who have pretty consistent florid psychotic states, living next door to folks who might have mild dementia. And those are different care environments.

The bottom line is we actually need to differentiate. I think that one of the things that we have done in this country is say that if you are above a certain income level, you're going to have bespoke everything. And if you're below a certain income level, I don't know, like good luck, God bless. And we can do better. We know enough to tailor our interventions. We know enough to tailor our long term supports. We know enough to say like scatter site's going to work for this population, not for this population. We do need to embed higher levels of care here. These don't need... Frankly, again, we've deployed those models to much success for people who can afford them.

So my question, I guess, or my statement would be if we actually seek solutions, then those solutions have to be for poor people too. And if I'm looking at radical collaboration driving towards equity, nothing is radical if it is inaccessible to poor people, full stop.

Rebecca Boss:

So how do you follow that? I would say we've heard a lot about disparate care and inequity in the system. We've heard a lot about the need for radical collaborations and partnerships. We've heard about the need for early childhood screening and prevention and healthcare and not separating out. We've heard a lot about silos. We've heard a lot about the different areas and separating people who are a whole person. And so understanding the sharing of personal experiences, people that we know, people that we've heard from today and understanding from what's going on with 988 implementation and the news that we all hear, there's an urgency. And for some, it's a personal urgency driven by experience, but for others you know that there's something that's going on. And so what can we do now that will enhance and/or accelerate this to improve collaboration across mental healthcare? What are those accelerators going to be? Do you think?

Marc Dones:

I can go.

I would just say the biggest accelerant for change that I have ever experienced in 15-ish years of public administration has been when we give power to the people who are impacted, like real power. And I want to really delineate here, if you'll allow me to wax briefly. If someone asks me to evaluate or

help them structure another advisory board, I will leave this country. That is not power, it is at best tokenizing and at worst, it is re-traumatizing. Because what I can tell you from being in hospitals, as I think a lot of folks can, is that what we often experience in mandated inpatient care is a total absence of power. Inability to do basic things like I would like to go to the bathroom now, wait. Maybe there are good care guidelines for some of those things, that's not what I am here to debate. What I want you to understand is that to take a bunch of people who experience powerlessness as a core function of the system and then put them in another powerless place is a form of re-traumatization and it is irresponsible.

Thank you. What I would say then is that the way to change that is to actually hand over material power, which is terrifying. It's very scary to be like, I guess you're going to make this choice, not me. But that is the thing that I have found to be the most significant accelerant, the thing that is most corrosive to silos is that handing over of real power. Again, I would look at my own agency and say helmed by a person with housing instability and two psychotic breaks and the hospitalizations to prove it. I think we do dope stuff every day. Since October, I ran the numbers earlier this week, we've housed more people since October than the system had previously managed to house deliberately in years. That's just because we work every day to be like, why doesn't this work? How can we hear what doesn't work and give the tools to change it to the people who are most impacted.

Reggie Williams:

I would say we have learned recently through this experience of the pandemic what it means to give flexibility to communities and people to direct how they do things. You think about some of the regulatory requirements that were eased around the use of telemedicine. Those are things that we need to do to be able to empower people to do what they believe is right for them.

And the second is creating flexibility in who I can actually be paid. If we take away the regulatory barriers and then we can actually pay more people to deliver the types of services that we want and determine the way that they want to deliver those services, it makes things more accessible to people. And so we just learned in this experience of the pandemic or what it means to give flexibility and pay the right people. We have an opportunity now to continue that going forward.

Melissa Rowan:

I would just add, mine will be much more boring than yours, but I think that's how this panel's going to go.

One is financing. We have a healthcare system in this country that is you have time and you get paid for your time. Now whether you get that paid in a fee for service or value based or whatever that might be, but you have to get paid. And the rates for mental health treatment are lower than any other sector of healthcare. And so, as long as that happens, when people go to medical school they're going to choose to be surgeons not psychiatrists. When they do other types of schooling, people are going to make different choices. And so we have to have equity in payment or you won't have equity in treatment.

And then the other part is if I have one more person ask me if that service has an ROI for mental health, is there any time, when your kid's diagnosed with cancer and you go and see that doctor, do they talk to you about whether or not there's going to be return on investment for the treatment that your child's going to get? They do not. But somehow every time we're trying to add comparable benefits into healthcare for mental health the question is what's the return on investment. And I don't see that in other forms of healthcare, if you want to ask me, what's the quality outcomes associated with that? I think that's a legitimate question. But if you're going to ask me what the ROI is, I think that's a

illegitimate question that a lot of us in behavioral health spend a lot of time answering. Which what we should say is why are you asking me that in the first place. This is a medically necessary service. This person has seen a professional who has diagnosed and recommended this treatment. And this treatment is what they need for their disease state. That's the answer, not whether or not there's a return on investment or their cost savings somewhere else in the system.

Rebecca Boss:

I love this panel. This is a great panel. As someone who is a former government official who thought she did a good job at community engagement, it's what you learn after you know it all that counts. And I received an education on what authentic community engagement is by a current colleague, and realized that I wasn't anywhere close to really implementing that strategy in making decisions and policies.

So I ask, as we've talked about importance of community engagement and listening to the people that are being served, are there examples of state, public, private partnerships that can break down those silos and really coordinate care in a more effective manner? And if there aren't current examples, what might be an ideal system?

Dr. Jennifer Bronson:

So I have an example. In my job, I'm researcher, and I spend a lot of my time talking to various states and localities and mental health centers to learn about their challenges. And recently we've been working with a lot of certified community behavioral health clinic, CCBHCs. And one in particular I just want to highlight some of the innovation and change that they've been able to do.

So, this group serves a rural catchment area of 12 counties in Northeastern Oklahoma Grand Mental Health, formerly Grand Lake Mental Health Center. And what they did is they developed this comprehensive wraparound crisis support system. It involves three parts. The first are urgent recovery centers. So these are separate from inpatient facilities and separate from crisis stabilization units. It's something new. It's where you can voluntarily admit yourself. Law enforcement can drop you off. You can stay as long as you need to be stabilized. There's no limit. They don't kick you out at 23 hours and 59 minutes. There's nurse practitioners. They get you medically stable. Get you emotionally more healthy. Or admit you to additional levels of care.

The second thing is they have iPads with a special MyCare app, and they've partnered with the software company to develop this. They've disseminated over a thousand of these iPads to clients, law enforcement, community centers, colleges, libraries. And what's great about them is there's a big red button, it's literally all there is, and you can press the red button and you get instantly connected to a crisis clinician by the second ring. Those clinicians are working, they're awake, they're on site at that urgent recovery center. And so if they determine through that crisis call that you could benefit from the URC services. That very same clinician may be the one meeting you at the door and beginning instant care coordination and integration.

So great. Y'all are saying this is lovely. So the outcomes, prior to this program being established in 2015, 841 adults went inpatient that year by 2020, that number was zero. By 2021 the number was zero. And part of what they have done as well is suicide prevention because you don't just press that crisis button when you're experiencing in crisis, you can push it when you're lonely, when you're sad, when you're anxious. I got a new puppy and there's no one home and I really want to share it. And that alone has dramatically improved wellbeing for some of their clients. Loneliness and isolation are some of the biggest risk factors for suicide. And so they are seeing this secondary ripple effect through this program.

Marc Dones:

A couple concrete examples. So one, I keep talking about my agency, because I'm really proud of it. In 2018 I was asked by then Mayor Durkan and Executive Constantine, Mayor of Seattle, Executive of King County to audit the homelessness system and say like, why doesn't this work? Shockingly, my recommendations were like, I don't know, this is barely a system, it's very fragmented and also none of the voices of the folks who need to be driving things are actually incorporated. So the current design, the constitution of the agency itself is 70% people with lived expertise. But we also have like an articulated governance structure that is real balance of powers with community. So I have a board until recently because he decided to come work at the agency, which is, I'm proud of to be honest, my board was co-chaired by a VA physician and someone who is currently living in a shelter. That is actual power sharing. Where it is not, again, an advisory board. It's like, I got to get approval from someone who lives in a shelter to make a policy decision. For real.

I think that the other thing that we've been able to do specifically in our public private partnership space, which I think is just broadly a space that we could lean into frankly, is through engaging community and bringing community to the table with some of our wealthiest businesses and philanthropic partners. We were able to get them to shift their investment strategy off of what it had been historically, which is like families and youth. In homelessness, if you're trying to raise a dollar it's like, look at this family and like the pocket's open. What we've never been able to do is raise money for who needs our help the most, which is single adults. People who don't have anybody and are inside a structure that is recognized by government and other places have historically dropped to the absolute bottom in terms of what is provided to them. And by bringing community to the table, again, through our governance model and our sharing of power, we were able to secure a $10 million investment just focused on single adult homelessness.

A thing that I often feel like a need to say is when we say the incorporation of lived expertise and talk about that power sharing, oftentimes people mistake these things for ideological positions. Like, oh, I'm a progressive I'm this, that, and the other. I may be those things off the clock. But as a public administrator, my job is to make the public dollar go as far as it can as quickly as it can. And to that end, incorporating people with lived expertise has given me faster results than 40 years of nonsense.

Rebecca Boss:

So I'm going to interrupt now our panel and say that this has been a wonderful and very rich discussion around collaboration and thank all four of you for your perspectives and willingness to present here today. This is the last panel of the day, and I want to make sure that we give the audience some time for questions before we move onto the next speaker. So your last chance to ask questions to this amazing group of individuals. There should be microphones around the room. If anyone has a question, there's one up here.

Silicia Lomax:

Thank you. Thank you all so much for being here. Silicia Lomax with Waxman Strategies in the Global Alliance for Behavioral Health. A question for all of you, if there's just one thing that you could take either from the programs that you've all worked with and for or that you've heard of yourselves, that you would like modeled in this potential perfect mental health world, what would that one thing be that you would take?

Melissa Rowan:

Collaborative care.

Rebecca Boss:

Reggie.

Reggie Williams:

For me, it would be giving primary care providers incentives and resources, and supports to bring in the type of mental health services that they need to serve their community. And so that's a wide variety of different people that could be paid or collaborate with the primary care provider.

Melissa Rowan:

I was going to say collaborative care. I think we're going on for the same one thing.

Marc Dones:

Shockingly, I would say shared decision making frameworks. Both obviously in the structure itself but then also in terms of what is my care and why is my care? Shared decision making frameworks have been developed fully implemented at SAMSA, there are whole like guidebooks on them and we do not use them enough.

Dr. Jennifer Bronson:

And I would say just kind of dovetailing on all of that is treating to get the outcome that the person needs instead of treating for billing.

Reggie Williams:

So true.

Sidney Mundra:

Hi, my name is Sidney Mundra. I work with the Advisory Board and we're currently doing behavioral health equity research, so this is apt. But there are obviously a lot of different stakeholders and players across the behavioral health landscape. If you were to think about who is prime to have the most impact on equity related behavioral healthcare or improving equity in behavioral healthcare. Whether that be payers or health systems or even federal and state governments. Who would you like to see movement from and or work with in order to achieve your work?

Dr. Jennifer Bronson:

I'll go first. So for me to move health equity forward, we will never do it until we acknowledge the structural and systemic reasons why we have inequity to begin with, and right now we still tip toe around that. So with health equity for example, we sometimes think about health disparities between Black and White Americans, but it's not race that is leaving people at risk for adverse health outcomes, it's racism. And that is a key point that we are missing in discussions about health equity. And this goes for all the different isms and all the discrimination and prejudice and security and stability that people face.

Marc Dones:

No notes.

Reggie Williams:

I'll go with Medicaid expansion. We know that most behavioral health services are delivered through Medicaid in our country and not every state has expanded Medicaid and there's an opportunity to provide services and supports to people that need it in our Medicaid program.

Rebecca Boss:

So we are actually at time and I want to thank you all for attending here today. Please join me one more time in thanking Dr. Bronson, Marc, Melissa, and Reggie for being with us today. It's an excellent panel.